Health Insurance Advisory Council

Minutes of January 17, 2006

5-6:30 P.M.

Hearing Room

Department of Business Regulation

233 Richmond Street

Providence, RI

Attendance:

Chairs: Chris Koller and Rick Brooks

Members: Hub Brennan, Dominic Delmonico, Howard Dulude, Dan Egan,

Annamarie Monks, Mike Frazier, Ann Rhodes, Peter Quattromani, Craig O'Connor

Patrick Quinn, Joshua Miller, William Martin, Denise Lynn

Health Plans: Tom Boyd, Jason Martiesian, Ken Pariseau

OHIC Staff: John Cogan, Patricia Huschle, Matt Stark, Adrienne Evans

Excused: Serena Sposato

Public Attendees: Maureen Glynn, Elizabeth Goudrais

1. Introductions

· Members of the Council introduce themselves to one another

· New Members Josh Miller, Bill Martin and Denise Lynn were welcomed to the Council.

2. Follow-ups Review of Minutes

· Review of minutes from December 20, 2005 meeting. Following change was made: under item 5 (Provider Health Plan Workgroup) " members of the Provider Health Plan Workgroup indicated the desirability of including administrators from the State Medicaid Program in this workgroup, to promote further standardization."

· Blue Cross Blue Shield of Rhode Island Board Compensation

Chris Koller referred to a summary of the Blue Cross Blue Shield of Rhode Island Board Compensation ruling, which was distributed at the meeting. Under the Administrative Procedures Act the decision is appealable by Blue Cross Blue Shield of Rhode Island. As of the meeting date there was no motion for appeal made (subsequent to the meeting OHIC was informed that the decision will not be appealed) Members of the Council expressed appreciation for the Office's decision and the efforts to inform them of the process.

· Direct Pay Hearing-Update

John Cogan informed the group of the proposed changes in the Direct Pay program submitted by BCBSRI members of the group asked for clarification regarding the process for rate adjudication and the theory behind it. The group discussed the challenges of rating the direct pay pool in a manner which is actuarially sustainable. Large amounts of price segmentation create more attractive rates for younger healthier members and encourage them to stay in or enter the pool but impose additional costs on older sicker members of the pool. Subsidies of the pool could come from other company business, the state, or other insurers. Alternately policies could attempt to include the pool in a larger group (such as small business). In addition, Blue Cross and Blue Shield of Rhode Island has proposed significant benefit changes including more consumer directed Health Plans (see below).

3. Consumer Directed Health Plans

The remainder of the meeting was spent reviewing the concept of consumer directed health plans, given their legislative approval in Rhode Island and their increasing popularity nationally, the following discussion points were raised based on materials distributed prior to the meeting

· Affordability: if detractors are concerned about the high deductible which makes the product affordable they need to come up with an alternative that costs the same amount. Much of these affordability concerns are driven by increasing medical costs.

· Provider concerns about cost shifting to patients and needed care that is foregone.

· There is a cost of chasing dollars from the patients for providers. Providers need real time notification of deductible enrollment. Dr. Brennan presented information on accounts receivable at Kent County Hospital rising with increasing insurance deductibles.

· The delivery system: How can we build a more efficient delivery system to keep costs low- for instance after hours primary care capacity?

· Effect on low-income populations, High deductible health plans discriminate against the sickest populations and those with low income-they cannot be relied on as a safety net.

· Experienced based rating and age adjusted rating: How much more should older and sicker people be expected to pay, since they utilize more? (Families with 16 year old boys pay more for their auto insurance)

· Prevention and wellness: How are these investments made, given that disease burden is increasing, if not through insurance benefits themselves?

· No infrastructure to disclose price or quality information to make us good shoppers if that is what the policy goal is.

· Administration: How do people find out how high deductible health plans work? Is it the responsibility of the employers, brokers, the health plans or regulators? There is not much reliable information.

· Small group + employers are not equipped to do this education. If they take up high deductible health plans it is an alternative to

offering no health insurance at all.

· Experience of large employers: Lifespan indicated it is taking a wait and see approach to high deductible health plans. They are not confident that their employees would know how to use them

· Empowered patients: Often as a patient you do not know what you need so how can you be an informed shopper.

Based on this conversation Chris Koller noted he is taking down the following points as ideas from the council regarding the implementation of High Deductible Health Plans

· When the high deductible Health plan option is offered, need to increase the percentage of time HSA are funded with the HDHP's. Otherwise, this becomes catastrophic health care.

· Link implementation of high deductible health plans to the availability of deductible and enrollment information for providers.

· Need to make quality and price information more available to patients/consumers if they are to make good choices.

· Need greater public awareness of how HDHP's work: responsibility of insurer, regulator and employer.

· Pay particular attention to small group purchasing of high deductible health plans since there are fewer employer resources here.

· Increase high deductible health plan use will not result in major delivery system investments to make it more efficient (i.e. increase primary care access).

· Increase HDHP use will not result in investment to decrease the

disease burden (public health).

· Need for greater education for what the inflation drivers are – not clear that "empowered consumers" can bring down this inflation rate by themselves.

4. Next meeting

Rick Brooks and Chris Koller reviewed the agenda for future meetings. The Council is now shifting into its work regarding appropriate reserve levels. On February 21 there will be a presentation by the Lewin Group and certain health plans regarding the appropriate reserve levels. On March 7th a second meeting of the Council will address remaining plans and invite public comment some background materials reserve levels on public policy were distributed at the meeting. The Council will be expected to listen to public testimony and have public discussion to provide advice to the Office of the Health Insurance Commissioner as they receive the results of the examination reports from the Lewin group. The public is invited to both of these meetings and interested parties will be invited to present specific testimony. The Office of the Health Insurance Commissioner will publicize these meetings beforehand.

(Subsequent to the January 17th HIAC meeting at the request of the Lewin Group the meetings were postponed by two weeks. March 7th will be the initial presentation by the Lewin group and March 21st will be the presentation by the plans. The agenda for the February 21st meeting will adjusted accordingly)